USC University of Southern California

Adolescent Trauma Training Center

Increasing Mindfulness and Metacognitive Awareness in Multitraumatized Adolescents: An Optional Module for ITCT-A and Other Treatment Approaches

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Introduction

This supplementary guide describes a mindfulness training approach that can be integrated into existing treatments for complex trauma in adolescents. Although it employs principles and techniques consistent with *Integrative Treatment of Complex Trauma for Adolescents* (ITCT-A; Briere & Lanktree, 2013), the interventions described here can also be applied to other trauma therapies for victimized youth (e.g., Himelstein, 2019; Semple & Madni, 2015). Mindfulness training is only one component of the many interventions used in ITCT-A (see Table 1) and is intended to be used as part of an integrated plan of care.

Those exposed to complex trauma in childhood and adolescence may suffer from a range of problems and symptoms, including not only posttraumatic distress, but also cognitive distortions, emotional dysregulation, substance abuse, and externalizing responses such as self-injury or problematic sexual behaviors. As a result, treatment for complex trauma effects often requires a number of different components, including relational therapy, exposure, emotional regulation training, and cognitive processing. Clinicians have recently added mindfulness-based interventions to this mix, since, as we will discuss in Chapter 2, most of the psychological difficulties associated with complex trauma have been shown in research to respond to mindfulness training.

Although mindfulness appears to be helpful for traumatized youth, its exact implementation in trauma treatment is not always straightforward. In most cases, validated mindfulness interventions (described in Chapter 1) are conducted in group settings, over short periods of time, and are focused on the acquisition of specific meditation and mindfulness skills. In contrast, interventions for complex trauma survivors often require intensive individual psychotherapy, within which the therapeutic relationship is paramount, and the focus is on the resolutions of acute symptoms and problems. In addition, the skill-set required of mindfulness teachers varies significantly from that needed for effective psychotherapy. The mindfulness teacher has their mindfulness practice, as well as training on how to teach it to others. Only one therapy model requires clinicians to learn both clinical skills and mindfulness facilitation. Mindfulness-Based Cognitive Therapy (MBCT) training is available to already-trained CBT therapists and focuses on the development of a personal practice and mindfulness facilitation skills. We will describe MBCT in more detail in Chapter 1. Practitioners trained in Acceptance

and Commitment Therapy (ACT; Hayes et al., 1999) and Dialectical Behavior Therapy (DBT; Linehan, 1993) optionally use mindfulness principles and skills, however, most trauma therapists are not trained in mindfulness, nor how to teach it, but have an extensive repertoire of clinical skills not found among many mindfulness facilitators.

We take a middle position in this guide, endorsing both the need for at least some mindfulness training and personal practice for any therapist who uses mindfulness techniques, but also emphasizing that, by itself, mindfulness training is unlikely to be sufficient to substantially assist adolescents who suffer the effects of complex trauma exposure. In this regard, we present simple meditation and mindfulness exercises that assist trauma therapy, but that do not require extensive therapist training in mindfulness. We also emphasize that the primary role of the therapist is to provide the therapeutic interventions he or she has been trained in (i.e., those that support stabilization, psychoeducation, trigger management, and cognitive and emotional processing of trauma memories). We also describe a hybrid therapy/mindfulness model in Chapter 4, which includes referral to a mindfulness group while the client also receives psychotherapy.

Table 1. Summary of the Principal Interventions Used in ITCT-A

Integrated Intervention Components
Repeated assessments
Early attention to safety issues and active safety interventions[1]
Advocacy and systems interventions
Psychoeducation
Distress reduction and affect regulation training
Mindfulness training
Cognitive processing
Titrated exposure
Trigger identification and intervention
Interventions for identity issues
Relational processing
Interventions to address maladaptive substance use[2]
Interventions with caretakers and family members
Group sessions

[1] A separate guide is available on the web at attc.usc.edu. (Briere, Lanktree, et al., 2019)

[2] A separate guide is available on the web at attc.usc.edu. (Briere & Lanktree, 2014)

Chapter 1. Mindfulness and Meditation

Mindfulness has been described as "paying attention, in a particular way, on purpose, in the present moment, and intentionally (Kabat-Zinn, 1994, p. 4). Mindfulness involves the learned ability to maintain ongoing awareness of—and openness to—immediate experience, including internal mental and physical states—thoughts, feelings, and bodily sensations. On the other hand, Walsh and Shapiro (2006) have described meditation as "a family of self-regulation practices that focus on training attention and awareness in order to bring mental processes under greater voluntary control and thereby foster general mental well-being and development and/or specific capacities such as calm, clarity, and concentration" (pp. 228-229).

Mindfulness is often learned through meditative practices. Common forms of meditation teach concentration, by maintaining attention to a single stimulus, for example, the incoming and outgoing breath, for relatively extended periods of time. During this activity, any thoughts, feelings, or sensations that arise are briefly noted without reactivity and then the individual redirects his or her attention to the breath. To the extent that it fosters internally directed awareness, meditation teaches mindful attention to the present moment. Increased mindfulness is, in turn, associated with a range of psychological benefits, as we describe in Chapter 2.

Importantly, mindfulness specifically increases the individual's capacity to accept (as opposed to resist) ongoing experience, and to do so impartially, observing their internal thoughts and feelings without labelling them as right or wrong, good or bad. Some trauma-related thoughts and emotions arise from the past (i.e., from previously experienced traumatic events). Others are focused on the future, such as anticipatory anxiety or worries about possible danger or maltreatment, albeit often based on prior experience. In contrast, mindfulness is the cultivation of present-focused attention. Giving attention to what is happening in this moment allows an adolescent to be less caught up in preoccupations about the past or worries about the future. The main components associated with the construct of mindfulness are shown in Figure 1 below.

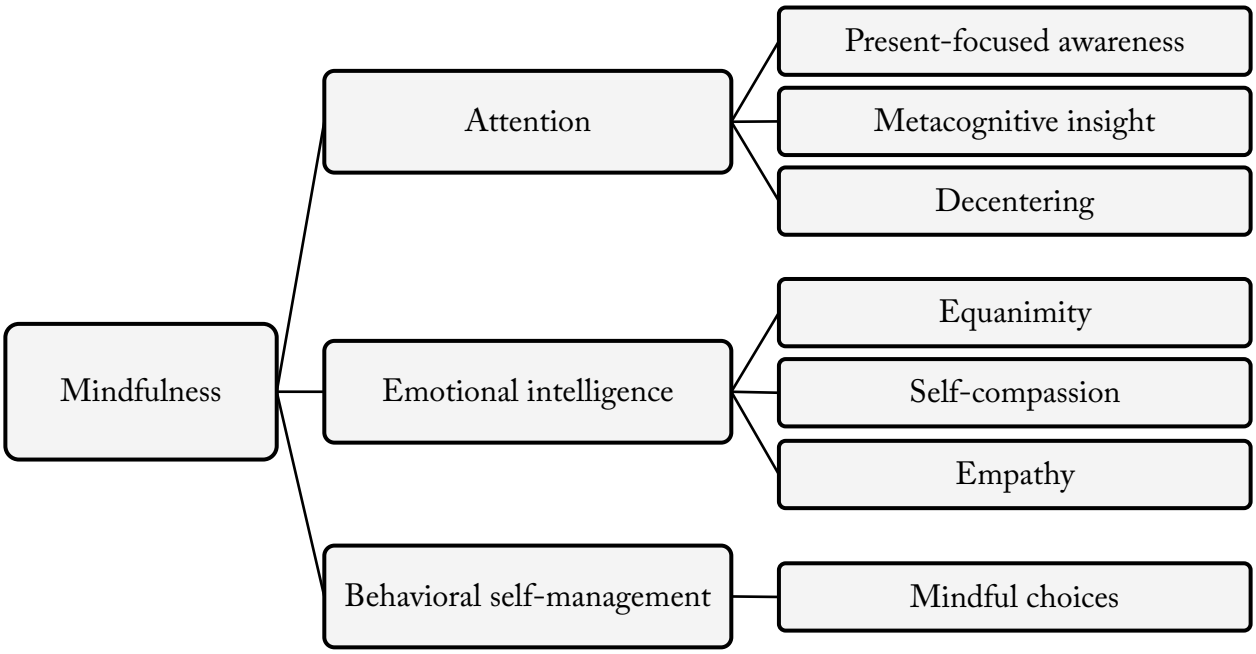

Figure 1. Components of Mindfulness

Mindfulness training teaches an attitude of acceptance toward everyday experiences that can be helpful in coping with the aftermath of trauma. There are a number of empirically supported mindfulness programs that have been shown to assist traumatized youth and adults. The most researched and widely known of these are:

- *Mindfulness-Based Stress Reduction* (MBSR; Kabat-Zinn, 1990, 1994)
- *Mindfulness-Based Cognitive Therapy* (MBCT; Segal et al., 2002, 2013)
- *Mindfulness-Based Relapse Prevention* (MBRP; Bowen et al., 2010)
- *Acceptance and Commitment Therapy* (ACT; Hayes & Strosahl, 2004)
- *Dialectical Behavior Therapy* (DBT; Linehan, 1993, 2014)

The most widely used mindfulness-based training programs—MBSR and MBCT—are described below in greater detail, since principles of each are incorporated into the approach presented in this guide.

Mindfulness-Based Stress Reduction (MBSR)

MBSR is the most commonly employed mindfulness intervention in North America. This is a structured program that involves eight weekly group sessions, each lasting approximately two and one-half hours, as well as one all-day session during the sixth week. In

addition to attending classes, participants are asked to meditate at home six days every week for 45 minutes each day. A central component of MBSR is instruction on how to practice mindfulness meditation, including:

- specific sitting and lying positions;
- focusing one's attention on a single target (for example, the breath or sensations in the body), and when, inevitably, the mind is distracted by emergent thoughts, emotions, or bodily sensations;
- noting these events in a nonjudgmental way and then returning attention to the target of attention.

MBSR also includes an exercise known as the *body scan,* which is a non-moving body-awareness meditation where participants are led through a guided exploration of sensations arising in the body, starting at the feet and eventually ending at the top of the head. Movement exercises include gentle stretching and yoga postures. A number of recent papers and studies suggest the specific usefulness of MBSR in the treatment of trauma survivors (see Hilton et al., 2016 ; Hopwood & Schutte, 2017 for meta-analytic reviews). Although MBSR has been used quite successfully in many clinical settings, it was developed as a community-based stress-management program and many MBSR facilitators are not trained psychotherapists.

Mindfulness-Based Cognitive Therapy (MBCT)

MBCT is the clinical adaptation of MBSR, initially developed to prevent relapse into depression, but is now being applied to other psychiatric domains as well. These include anxiety (Evans et al., 2008; Semple & Lee, 2011), acute depression (Ames et al., 2014; Barnhofer et al., 2009) and bipolar disorder (Ives-Deliperi et al., 2013; Miklowitz et al., 2015). MBCT is also being investigated as a treatment component for obsessive-compulsive disorder (Key et al., 2017; Külz et al., 2014).

MBCT also involves eight weekly sessions and an all-day retreat, and teaches many of the same skills as MBSR. However, MBCT especially encourages participants to develop a metacognitive perspective on their thoughts, whereby upsetting cognitions or distress-related thinking patterns are recognized as merely thoughts—not necessarily as evidence of the true state of reality. When they occur, such cognitive intrusions (for example, "I am a bad person," "things are hopeless") are not suppressed, but instead are noted objectively and considered mindfully as normal aspects of the mind—ones that inevitably come and go, but do not necessarily have

intrinsic meaning or truth. We will discuss metacognitive awareness in more detail in Chapter 3 and its role in managing trauma triggers in Chapter 7. There are fewer studies on the efficacy of MBCT with trauma survivors, although several studies have reported its utility (King et al., 2013; King & Favorite, 2016; Sears, 2016). The first author of this guide, Randye Semple, has developed a child-friendly version of MBCT (Mindfulness-Based Cognitive Therapy for Children (MBCT-C; Semple & Lee, 2011), which is highly applicable to traumatized youth (Semple & Madni, 2015). MBCT-C has also been evaluated as a treatment for anxious adolescents (Cotton et al., 2020; Cotton et al., 2016; LaGue et al., 2019).

Chapter 2. What is Complex Trauma?

Complex trauma can be defined as a combination of early (e.g., in childhood) and later-onset (e.g., in adolescence) traumatic events, usually of an ongoing, interpersonal nature. In most cases, such traumas include exposure to sexual, physical, and/or psychological abuse, often in the context of concomitant caretaker neglect and and/or disattunement, frequently leading to—and exacerbated by—dysregulated attachment (Briere & Scott, 2015; Cook et al., 2005). As delineated in the literature (e.g., Cloitre et al., 2011; Ford & Courtois, 2014; van der Kolk, 2005); the impacts of complex trauma include significant

- anxiety and depression,
- dissociation,
- relationship problems,
- identity disturbance,
- problems with emotional regulation,
- cognitive distortions,
- somatization,
- distress-reducing behaviors such as self-injury and compulsive sexual behavior,
- maladaptive substance use,
- eating disorders, and
- susceptibility to revictimization.

When of sufficient number, complexity, and severity, these symptoms and problems are sometimes referred to as *Complex PTSD* (C-PTSD; Herman, 1992) or *Developmental Trauma Disorder* (DTD; Spinazzola et al., 2018). Although not included in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013), C-PTSD does appear in the 11th edition of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11; World Health Organization, 2019). C-PTSD involves most of the symptoms and problems listed above, but also those of "simple" PTSD, such as reliving symptoms (e.g., flashbacks, nightmares), behavioral avoidance, numbing, hyperarousal, mood disturbance, and cognitive distortions (Böttche et al., 2018; Cloitre et al., 2011).

The relational, identity, and emotional regulation problems associated with C-PTSD and

DTD include the tendency to be involved in chaotic and frequently maladaptive relationships, difficulties in negotiating interpersonal boundaries, reduced awareness of one's entitlements and needs, and difficulties tolerating and regulating triggered emotional states. These specific problems are often associated with a history of inadequate or disrupted parent-child attachment (Cassidy & Shaver, 2018; Sroufe et al., 1999), which is a common component of complex trauma (Bailey et al., 2007; Ford & Courtois, 2014).

Problematic Avoidance Behaviors

A common result of complex trauma exposure, perhaps especially in adolescents and young adults, is involvement in avoidance behaviors that, although potentially useful in the moment, lead to negative outcomes and, potentially, life risk. Two of the most problematic types of trauma-related avoidance are excessive or risky substance use and distress reduction behaviors (DRBs; Briere, 2019). In many cases, these activities serve as coping responses to the cognitive and emotional effects of trauma memories that are triggered by reminiscent stimuli in the current relational environment (Briere et al., 2010). This is especially the case when the memories both (a) produce great distress, and (b) overwhelm the client's (often underdeveloped) emotional regulation capacities. When this occurs, the individual may need to rely on behaviors or substances that reduce awareness of emotional pain (Briere & Scott, 2015). Many of these activities tend to get adolescents "in trouble," and may be self-defeating, if not life threatening. For this reason, beyond its focus on posttraumatic stress and dysphoria, ITCT-A (including its optional mindfulness component) particularly attends to problematic avoidance behaviors.

Substance abuse. Substance abuse is correlated with trauma exposure in a number of studies (Cisler et al., 2011; Hedtke et al., 2008; Khoury et al., 2010; Ouimette & Brown, 2003), and is a common response to complex trauma (Briere & Lanktree, 2014). There are at least two reasons why trauma survivors are prone to problematic substance use (Khantzian, 1997):

- as a way to numb emotional pain, and
- because euphoric states associated with substance use are generally incompatible with distressing feelings.

Unfortunately, alcohol and drug abuse is associated with a range of negative outcomes, including physical illness, reduced inhibitions that lead to reckless or risky behaviors, more frequent accidents, and a greater tendency to be revictimized by others. ITCT-A has a specific treatment guide for substance using adolescent trauma survivors (Briere & Lanktree, 2014).

Notably, however, mindfulness approaches may be especially helpful in this area, including techniques used in Mindfulness-Based Relapse Prevention (MBRP; Bowen et al., 2010) such as *urge surfing*, which is described in Chapter 7.

Distress reduction behaviors (DRBs). DRBs can be defined as any external behavior that serves the purpose of blocking, neutralizing, or distracting from triggered, painful internal states. DRBs are commonly associated with complex trauma, especially childhood abuse and/or neglect, and are a central focus of treatment in ITCT-A. Typical DRBs include, but are not limited to:

- nonsuicidal self-injury, such as self-cutting or burning (Briere & Eadie, 2016; Walsh, 2014),
- compulsive or risky sexual behavior (Vaillancourt-Morel et al., 2016),
- binge eating and purging (Briere & Scott, 2007; Rosenbaum & White, 2013),
- aggression (Ford et al., 2012; Godbout et al., 2017),
- suicidal behavior (Briere, Kwon, et al., 2019; Hjelmeland & Knizek, 2010), and
- problematic internet use (Eichenberg et al., 2017).

Such behaviors are often characterized in the clinical literature as signs of a conduct disorder, or for older youth, behavioral addiction, borderline personality disorder, or antisocial personality disorder. As noted earlier, recent research suggests that DRBs occur when a relational stimulus in the environment (e.g., perceived maltreatment, rejection, or abandonment) triggers early attachment- or trauma-related memories, which overwhelm the adolescent's emotional regulation capacities and lead to avoidance behaviors (Briere & Scott, 2015). DRB-related avoidance may, among other functions, serve to:

- distract from painful internal states;
- self-soothe;
- provide distress-incompatible emotional experiences;
- offer momentary interpersonal connection;
- self-punish, as a way to reduce guilt or shame;
- communicate emotional distress (i.e., a "cry for help"); and/or
- provide an increased sense of control.

Although DRBs are often characterized as being difficult to treat, mindfulness interventions have been shown to be helpful for a range of problematic or risky behaviors, including self-injurious behavior, aggression, bulimia, suicidality, and other behaviors associated

with trauma and emotional dysregulation (Coelho et al., 2007; Grossman et al., 2004; Hilton et al., 2016; Hofmann et al., 2010; Khoury et al., 2013).

Chapter 3. How Mindfulness Reduces Complex Trauma Effects

It is not surprising that mindfulness interventions have been shown to be helpful for child abuse survivors (e.g., Kimbrough et al., 2010; Steil et al., 2011); veterans (Kearney et al., 2012; Stephenson et al., 2017); and survivors of intimate partner violence (Dutton et al., 2011). Research further indicates the effectiveness of mindfulness training (including DBT and ACT) in mitigating phenomena associated with complex trauma, including:

- posttraumatic stress (Bremner et al., 2017; Davis et al., 2019; Hilton et al., 2016; Hopwood & Schutte, 2017),
- anxiety and depression (Hofmann et al., 2010; Segal et al., 2013),
- dissociation (Sharma et al., 2016),
- negative thoughts and self-perceptions (Randal et al., 2015),
- emotional dysregulation (Huang et al., 2019),
- self-injury (McCauley et al., 2018),
- suicidal behavior (Forkmann et al., 2014),
- problematic substance use (Bowen et al., 2006; Davis et al., 2007),
- bingeing and purging (Kristeller et al., 2006; Masuda & Hill, 2013),
- aggression (Fix & Fix, 2013; Heppner et al., 2008), and
- borderline personality disorder (Kliem et al., 2010; Ost, 2008).

Potential Mechanisms of Effectiveness

Although the specific mechanisms whereby mindfulness addresses trauma effects are not completely known, aspects of mindfulness meditation likely contribute to the mitigation of complex trauma effects. There are at least five potential pathways.

Development of settling skills. Mindfulness helps the client to reduce his or her anxiety and autonomic arousal, generally by (a) activating the stress-reducing parasympathetic nervous system (Tang et al., 2009), and (b) teaching him or her how to not get caught up in intrusive or persistent thoughts and feelings as they arise. As the client learns how to "calm down" through meditation practice, and then applies these skills to trauma-related states and experiences, they are more able to counter the symptoms of PTSD (especially hyperarousal and other "fight or flight" responses), as well as reducing enduring emotional states that otherwise might motivate the use of substances or DRBs.

Metacognitive awareness. During mindfulness training, the client is invited to consider his or her trauma-related cognitions, feelings, and memories as "just" products of the mind—phenomena that are not necessarily real in the current context, but that reflect re-experiencing of past trauma or insecure attachment. The intent is not to convince the survivor that memories are always irrelevant, or invalidate an intense emotional experience, but rather to facilitate increased awareness that such phenomena are reflexive actions of the mind or brain, and are not always accurate feedback about the current environment or state of reality. This changed relationship to thoughts and feelings allows the youth to be less reactive to unwanted or uncomfortable cognitions or feelings that, in turn, can decrease posttraumatic stress and/or overwhelming states that lead to DRBs or problematic substance use.

Trauma processing through exposure. Various writers (e.g., Germer, 2005; Treanor, 2011) have suggested that the decreased avoidance associated with mindfulness potentially increases the individual's access to emotionally laden memories in the specific context of a relaxed state and with a more dispassionate, nonjudgmental, and accepting cognitive perspective. This activity supports the processing and counterconditioning of traumatic memories, thereby decreasing their power to produce distress (Briere, 2012). This form of exposure has been described by Buddhist writers as "inviting your fear to tea" or "leaning into fear" (e.g., Brach, 2003). In the therapy session, it may be engaged by asking the client to recall traumatic events and allow the attendant emotions to unfold without resistance or judgment. To the extent that this process leads to extinction learning (Treanor, 2011), mindfulness may reduce the painful emotions associated with specific traumatic memories, and thereby lessen posttraumatic stress.

Increasing distress tolerance. Especially noted in DBT, mindfulness interventions can increase the individual's capacity to tolerate painful emotional states. This occurs when the individual learns to "sit with" unwanted emotions, including those triggered by trauma- or attachment-related stimuli, without significant avoidance and without acting on them. Some of this capacity likely relates to the decatastrophizing effects of metacognitive awareness (e.g., "this isn't real, these are just feelings from the past"), and the effects of settling skills (including focused breathing) on perceived distress. However, it also may reflect a growing realization that feelings can be nonjudgmentally accepted and tolerated, often to a greater extent than previously assumed. As the individual allows himself or herself to feel greater amounts of unwanted feeling, they may become "better" at it, eventually being able to tolerate emotional states that previously

would have been overwhelming and potentially associated with substance use and DRBs.

Appreciating the benefits of ongoing awareness versus avoidance. Although under-examined in the empirical literature, clinical experience suggests that the benefits of mindfulness are diametrically opposed to the primary results of substance use, distracting behaviors, and other avoidance activities. When practiced regularly, mindfulness can lead to an increased sense of well-being (Galante et al., 2014; Goyal et al., 2014), self-control (Black et al., 2011), and a greater enjoyment of the "here-and-now," as opposed to the internal and external chaos, deadening, and self-endangerment often associated with DRBs and problematic levels of drug or alcohol use. To the extent that mindfulness increases appreciation of the current moment, and addresses the emotional pain associated with complex trauma, the youth may find that he or she is less invested in numbing, distracting, or suppressing activities, and more willing to engage the benefits of being more grounded, aware, and experientially "alive."

Chapter 4. Orientation to Mindfulness Training for Adolescents

There are two general approaches to teaching mindfulness to complex trauma survivors, referred to as *direct* versus *hybrid* models (Briere, 2013). In the direct approach, clients are initially taught mindfulness (and often meditation) skills as a part of, or as a precursor to, trauma therapy. As noted earlier, this requires the therapist to also be a qualified mindfulness teacher. It also presupposes that the youth can tolerate mindfulness training (which we discuss next), and is not so debilitated that he or she first requires the extensive stabilization, support, and processing components of good trauma therapy.

By contrast, in the hybrid approach, the adolescent initially receives trauma therapy and, if appropriate, is then referred to a mindfulness class while continuing to engage in treatment. As mindfulness skills are developed, the clinician gradually integrates mindfulness activities into the treatment process. This approach has the benefits of providing both therapy and mindfulness training, delivers important early therapeutic services for vulnerable clients, and does not require as much mindfulness expertise on the part of the therapist. However, mindfulness and therapy may be less integrated in this approach, and not all youths will have the financial, geographical, or psychological resources necessary to obtain separate mindfulness training.

In this guide, to some extent, these approaches will be combined. Presented below is our suggested approach to integrating mindfulness into psychotherapy, which involves multiple decision points along the way that determine what happens and when.

Combining Mindfulness with Trauma Therapy

Evaluate the severity of complex trauma effects. Adolescent clients with major trauma histories may be experiencing outcomes that should be addressed before any mindfulness training begins (Germer, 2005; Shapiro Jr., 1992; Williams & Swales, 2004). These include:

- acute suicidality;
- severe posttraumatic stress or dissociation;
- clinical levels of depression or anxiety;
- psychosis;
- bipolar affective disorder;
- extreme substance use; and
- major emotional regulation difficulties, with associated affective instability and often,

risky DRBs.

Evaluate the appropriateness of mindfulness training. Even if the adolescent does not demonstrate major, acute psychological symptoms or instability, it may still be the case that mindfulness training is not appropriate for him or her, or should be delayed. Because meditation and mindfulness, by definition, reduce avoidance and provide greater exposure to internal experience, including memories and painful emotional states, clients who are not able to tolerate such changes may be challenged by mindfulness training. In fact, several studies suggest that, in some cases, meditation can have unwanted side effects (Cebolla et al., 2017; Schlosser et al., 2019). Although most youth who are not suffering severe trauma effects may be able to tolerate training, this should be an assessment question rather than something that is assumed.

The youth's environment is another area to assess for contraindications. Potential environmental concerns include homelessness, or being in an unsafe, unstable, or chaotic home environment (Himelstein, 2019; Semple & Madni, 2015). If the youth is asked to practice mindfulness at home, having a space that feels physically, emotionally, and interpersonally safe is essential. If this is not available, then encouraging home-based mindfulness practice is not recommended, although some mindfulness exercises may still be practiced in the therapist's office.

Typically, contraindications to mindfulness will become apparent either because the client directly reports previous difficulties in this area, or when he or she has negative reactions when first attempting to meditate. Indicators of problems in this area include reports of any of the following when engaged in meditation:

- notable increase in anxiety,
- fear of loss of control,
- dissociative experiences,
- intrusive distressing memories, or
- psychosis-like symptoms.

It should be noted that minor increases in anxiety are relatively common when beginning meditative practices. This may be accompanied by negative self-talk regarding the practice itself. For example, a youth may tell him or herself, "I'm not doing this right" or "I'm terrible at this—my mind is all over the place." Minor increases in anxiety associated with negative self-talk is often not a contraindication, but rather an opportunity for the youth to better understand that

thoughts can be influential in affecting his or her emotional state.

Normalizing the experience of such "mind wandering" can be facilitated by first indicating that this is both normal and expected, and then clarifying that the intent of meditation practice is not to strive for some flawless (unattainable) attentional focus, but rather to practice noting the inevitable wanderings of the mind, and then making a mindful choice—with self-kindness instead of self-judgment—to refocus attention back to the breath. Like training an exuberant puppy, training the mind requires patience, persistence, and gentleness (Kornfield, 1993).

For those without contraindications. These clients can be referred to a mindfulness training group or a qualified meditation training center. This approach requires some, but not extensive, therapist mindfulness training. In this case, the client is able to receive needed therapy, but also learns the skills and perspectives outlined in Chapter 3, such as settling, metacognitive awareness, and the development of greater distress tolerance. As needed, these skills can be integrated into treatment. When the adolescent is simultaneously participating in psychotherapy and mindfulness training (for example, an MBSR or MBCT program), the meditation-experienced therapist can monitor and inform the process, helping the client to understand and integrate mindfulness principles and activities as they are relevant to his or her trauma history.

For those who require immediate treatment and stabilization. These clients should be provided trauma therapy without specific mindfulness components. This requires no particular mindfulness training on the part of the clinician. Adolescent clients in this category often present with severe posttraumatic symptoms, reduced emotional regulation capacities, and sometimes risky DRBs. The ITCT-A Treatment Guide (minus the mindfulness chapter) or another structured trauma treatment protocol should be followed for such individuals, with significant attention to stabilization and emotional regulation interventions before formal trauma processing is begun. Notably, this approach may be changed as the client improves clinically, and is able to tolerate some mindfulness training.

For those who fall in the midpoint. These clients can initially be provided trauma therapy, but can be gradually introduced to basic mindfulness techniques and exercises as indicated, potentially followed by referral to a meditation center, if possible. This, however, may be less feasible for marginalized youth with complex trauma. This approach requires that the therapist have significant mindfulness training and, ideally, a personal meditation practice. Even when the

client is not overwhelmed by trauma/attachment symptoms, and is able to tolerate mindfulness training, the therapist should continually assess what the youth needs most at any given point in the treatment. When appropriate, the mindfulness-trained clinician can introduce elementary meditation instruction and mindfulness exercises. At the same time, however, it is important to attend to the precepts and practices of good trauma therapy. Because many complex trauma survivors fit into this midpoint category, the remaining chapters of this guide will focus primarily on this approach.

Teaching Mindfulness from a Trauma-Informed Perspective

A number of trauma-informed clinicians and mindfulness facilitators have offered tips, tools, and cautions about teaching mindfulness to trauma survivors. No interventions are universally effective or without potential negative effects. Willoughby Britton (2019) observes that many mindfulness studies fail to measure unintended or adverse effects, and published mindfulness research often downplays null or negative outcomes.

Mindfulness has been likened to the backdraft in a fire (Germer & Neff, 2014). A backdraft is an explosion of fire caused by introducing oxygen into a burning, oxygen-depleted space, for example, when a door is opened. Backdrafts are dangerous to firefighters, and can be challenging for clients as well. Mindfulness opens the heart and the mind. But sometimes, what pops out may include distress.

Five Principles of Trauma-Sensitive Mindfulness

David Treleaven (2018) outlines five important principles to keep in mind when teaching mindfulness to trauma survivors.

First, stay within the client's window of tolerance. It is essential for any trauma-informed clinician to understand each client's window of tolerance and be able to help him or her down-regulate intense emotions when needed. It's also vital to empower clients by letting them know that they can choose to end a practice if it ever begins to feel too intense.

Second, shift attention to support stability. The path to recovery from trauma involves observing and tolerating distressing thoughts and emotions. However, too much attention too soon might increase trauma symptoms. Grounding interventions can be used if intense thoughts or emotions arise during a meditation exercise. Invite your client to open his or her eyes, and look at a picture on the wall or an object in the room. You might direct him or her to stand up, and then focus attention on the sensations in the soles of the feet. Or teach the adolescent to

shift his or her attention by touching a calming object kept nearby for this purpose (e.g., a squeeze ball, a silk scarf, or a plush toy).

Third, keep the body in mind. Posttraumatic distress lives in the body as well as the mind. Body-focused meditation practices such as the *Body Scan*[3] sometimes can be triggering and we recommend avoiding these and other prolonged body-awareness exercises, at least earlier in treatment. Instead, short movement practices can help the client reconnect with his or her body in a way that feels safe and at their own pace. In this regard, there is no need to get too "hung up" on the logistics of meditation. If your client feels safer not dwelling on bodily sensations, or sitting or standing with his or her back against a wall with eyes open to meditate, that is perfectly acceptable.

Fourth, practice in relationship. Traumatized teens often have been hurt by others—sometimes directly and sometimes because important figures did not protect or support them when they were really needed. Feelings of danger and unpredictability may easily lead to hypervigilance, heightened autonomic arousal, and easily provoked anxiety. Through the therapeutic relationship, the trauma-informed clinician can increase the client's sense of safety, support, and acceptance—conditions that are essential to not only the development of mindfulness skills (Himelstein, 2019), but, more generally, the effectiveness of psychotherapy (Seligman, 1995). Practicing in relationship means that we leverage the therapeutic relationship for the benefit of our clients—our own calm, reassuring presence bolsters their sense of safety, stability, and increases their ability to cope with strong thoughts and emotions.

Fifth, understand the social context. It is also important to consider the social environment within which trauma arises for many youth. As discussed extensively in the ITCT-A Treatment Guide, trauma often occurs in the context of social and cultural inequities, discrimination, and exploitation within families, communities, institutions, and social norms. Treleaven notes that understanding social context in therapy does not mean that the clinician needs to know everything about each client's cultural, racial, sexual, or ethnic environment, which is often different from our own. Rather, understanding the social context means that

[3] The *Body Scan* is a non-moving meditation exercise that is used in both MBSR and MBCT. It is generally done with the individual lying face-up on the floor with eyes closed, and then paying attention to parts of the body and bodily sensations in a gradual sweeping of attention through the body from feet to head. With adults, this practice typically lasts 40-45 minutes.

> *"...we can see and acknowledge difference—knowing that each of us has a unique history and is being shaped in a particular way by the systems around us. It also means that we can skillfully navigate difference and help someone to feel safe in the context of working with mindfulness and trauma. If we fail to actively engage with social context, we become a liability in our mindfulness-based work. Absent an understanding of how individual and social systems interact, we can potentially cause harm, break people's trust, and perpetuate systems of domination." (p. 179).*

Keeping these principles in mind, we now turn our attention to the "nuts and bolts" of teaching mindfulness to adolescents.

Chapter 5. Teaching Meditation

Although it is possible to develop some mindfulness skills without engaging in meditative practices, in most cases the most efficient path toward mindfulness includes formal meditation training. As described in Chapter 4, meditation is appropriate if:

- the youth is not unduly compromised by symptoms, and appears able to tolerate mindfulness training;
- the clinician is sufficiently trained in meditation and mindfulness that he or she can teach basic skills in this area to the client; and
- following initial attempts at meditating the youth does not report significant negative or upsetting states.

Importantly, as noted previously, such instruction should only occur when intensive trauma therapy is not more immediately indicated. For example, a young client who is receiving meditation instruction may, either as a function of reduced avoidance or due to external circumstances, experience an increase in posttraumatic stress, or an increased desire to engage in a DRB-like self-injury or risky sexual behaviors. In this instance, the appropriate intervention is likely to be (a) at least momentary cessation in meditation training, and (b) increased use of therapeutic components that explicitly stabilize and support the survivor. In many cases, the client will be able to return to meditation activities as these issues become less prominent. In other cases, it may be decided that trauma therapy should be utilized by itself for the time being.

Once meditation training has been agreed upon and contraindications have been ruled out, the clinician and youth should decide on certain meditation parameters. These include mutually agreed upon expectations about the type, duration, and frequency of meditation practices.

Type of Meditation

There are a number of different types of meditation. Some involve sitting, walking, or chanting, whereas others include specific movements or body positions (e.g., yoga, t'ai chi, and qigong practices). Some focus especially on the breath, or an external object of attention such as a sound or a candle flame, while others use *mantras* (a word or short phrase that is chanted over and over). Other practices specifically focus on cultivating self-compassion and gratitude. Although any of these meditation approaches likely can be helpful in work with traumatized

youth, we generally suggest starting with a breath-focused, mindfulness-oriented approach. However, we also provide guidance to facilitate some mindfulness exercises involving focused attention on stimuli other than breath, and in Chapter 7, we describe a method of developing metacognitive awareness that does not necessarily require meditation.

Instructions for several mindfulness and meditation exercises are included in the next chapter. However, therapists with experience and training in another meditation model may choose to substitute that method for the current one, ideally while still following the general guidelines described here.

Duration of Meditation Periods

Because, on average, younger adolescents tend to have a shorter attention span than older ones, we recommend that the duration of any given meditation be roughly determined by the client's age, as well as his or her capacity to sustain meditative attention. In general, meditation periods for adolescents exposed to complex trauma are short as compared to adults, with the youngest clients potentially starting at 1-5 minutes, and older youth not exceeding 15 or 20 minutes per session. As the client gains meditative capacity, however, these session times may be expanded.

Frequency of Meditation

Although actual meditation periods may be relatively short, it is important that the youth practice meditating multiple times a week, so that he or she has the opportunity to develop the relevant skills. In fact, if possible, we recommend that the adolescent meditate at least four or five times every week, even if any given meditation period is short. Experience suggests that near-daily practice, even if the session is short, can be more effective than meditating only once weekly for a longer duration. This may be conveyed to the youth with some version of the following, paraphrased, and further explained as needed.

> *"If you can, try to meditate at least __ times a week. Try to do it for __ minutes each time. If you only can meditate for shorter period of time, that is ok, too … the most important thing is that you try to do it at least __ times a week."*

The Daily Meditation Record

As we noted earlier, remembering to meditate initially can be a challenge. Some adolescents may have more success if they are given a simple worksheet, as shown in Figure 2, on

which they can enter each meditation period they completed over the prior weeks, the date when they did it, the duration of each, as well as the difficulty involved. The printable worksheet appears in Appendix A. The youth can use the last column to note the type of meditation done or notable qualities of a particular practice. This sheet can then be shared with the therapist, and, when all rows have been completed, a new one provided to the client for the next week. If there is a supportive caretaker available, it may be helpful to solicit his or her help in reminding the client to meditate and/or to complete the worksheets. If the caretaker relationship is more adversarial, it may be better to avoid caretaker input or guidance.

Note that the "how many minutes" and "how did it go" columns should not be viewed as value judgments about how well the client is doing in the meditation domain. Instead, the clinician should stress that these questions are just for information. As the youth and therapist go over these columns, the clinician will have the opportunity to explore with the adolescent whether the meditation period should be shortened or increased, whether there are any unwanted side effects associated with any of the specific meditation exercises, or whether there are questions the client might have about the meditation process. It is also an opportunity to emphasize the uniqueness of each day's practice, normalize any difficulties, and to praise the youth regarding the effort needed to develop a consistent practice.

Daily Meditation Record Name________________________________

Date	How long did you meditate today? (check one)	How did it go? It was easy	It was okay	It was hard	Notes
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	

Figure 2. Daily Meditation Record

Mindful Exploration of Trauma

Allowing adequate time each session to dialogue about the youth's meditation practice

and how it might be useful in their everyday life is an important component in trauma processing for several reasons. First, describing the experience clarifies and reinforces any insights or understandings he or she may have gained during the exercises. Second, it gives the therapist opportunities to correct any misconceptions about meditation that may interfere with progress, including that meditation is about stopping or controlling thoughts or emotions; that meditation should be easy (or is too hard); that meditating must be done with eyes closed or sitting in lotus position; and that meditation is the same as relaxation or self-hypnosis. Third, discovering personal reasons to meditate is essential to understanding and reinforcing the value of a consistent practice. Without having strong and compelling personal reasons, adolescents are unlikely to maintain a daily practice. Benefits can include:

- feeling calmer and less stressed out;
- reduced experiences of anxiety and depression;
- less frequent or less intense bouts of anger;
- greater self-awareness;
- more self-confidence;
- improvements in attention that can support academic or athletic performance;
- better self-management of impulsive, risky, or self-injurious behaviors;
- improvements in sleep; and
- feeling more connected with others.

Questions to Facilitate Mindful Exploration of Trauma

Mindfulness of thoughts

- "How do you know when you are feeling [afraid, anxious, sad]?"
- "What are you thinking at those times?"
- "What are you telling yourself about feeling [fear, anxiety, sadness]?"
- "Could our own thoughts make a situation worse than it really is? How does that happen?"
- "Could practicing mindfulness protect you from being hijacked by your own thoughts?"

Mindfulness of body sensations

- "What are the sensations in your body when [fear, anxiety, sadness] come up?"
- "Can you explore and describe those sensations? What happens to the

sensations when you explore them?"

- "How might our bodies trick us into feeling [afraid, anxious, sad]?"

Mindfulness of emotions

- "What does it feel like to be mindful of [fear, anxiety, sadness]?"
- "How is this different than just being [afraid, anxious, sad]?"
- "How can you tell that these feelings are different than more positive or pleasant emotions?" For example, the body sensations of intense fear and the body sensations when running hard on a treadmill are similar.

Mindfulness of actions

- "How do you respond when you feel [afraid, anxious, sad]?"
- "Is this what you clearly choose to do or do you feel pushed around by your thoughts or emotions?"
- "Could mindfulness help you create space between your thoughts, feelings, and behaviors so that you respond less impulsively and more skillfully."

Mindfulness overall

- "What part of the experience of [fear, anxiety, sadness] is most upsetting to you? The thoughts? The feelings? The body sensations? What about the uncertainties?"
- "How can other people tell what you are feeling?"
- "Does practicing mindfulness help when you're not feeling [afraid, anxious, sad]?"
- "When you are feeling [afraid, anxious, sad], how might you remember to look for choices?"

Responses that might be helpful

- "Notice that my thoughts are thinking about something that has already happened (or something that hasn't even happened yet)."
- "Take several deep breaths."
- "Relax my body by practicing mindful slow walking."
- "Tell myself that my thoughts are probably worse than what is really happening right now."
- "Stop and ask myself if I'm being triggered or on autopilot right now."

- "Look for my choices."

Phone Apps

Mindfulness is typically not hard to do, but it can sometimes be hard to remember to do it. Phone apps can be useful tools with which to support the development of daily practice. Dozens of phone apps are available for both Apple and Android that offer a wide variety of guided meditation practices. Some include social networking components that can be very appealing to teens. Because there are so many, we will only describe a half-dozen apps that may be particularly useful when working with traumatized teens.

iChill. This app teaches mindfulness skills based on the Trauma Resiliency Model (TRM), which focuses on the biological basis of trauma and the automatic survival responses that the human body uses when faced with perceived threat. TRM explores the concept of resiliency and offers guided practices in skills such as grounding, breath and body meditations, and shifting attention to manage acute distress. At this time, *iChill* is available at no cost.

Website: http://www.ichillapp.com

Apple: https://apps.apple.com/us/app/ichill/id403527676

Android: https://play.google.com/store/apps/details?id=com.tritrc.ichill

Mindful USC. The University of Southern California has developed an app with guided meditations focused on managing difficult emotions—calming down, improving concentration and sleep, lowering anxiety, and enhancing resilience. Some of the meditation practices are offered in Spanish. At this time, *Mindful USC* is available at no cost.

Website: https://mindful.usc.edu/mindful-usc-mobile-app/

Apple: https://apps.apple.com/app/id1291768924

Android: https://play.google.com/store/apps/details?id=edu.mindful.usc

Liberate Meditation. This app showcases content that was developed specifically for the Black, Indigenous, and People of Color community. It includes a large database of guided meditations by teachers of color. Topics range from dealing with microaggressions to cultivating lovingkindness for difficult people. Users can select meditation practices ranging from 5 to 20 minutes. At this time, *Liberate Meditation* is available at no cost.

Website: https://liberatemeditation.com

Apple: https://apps.apple.com/us/app/liberate-meditation/id1451620569

Android: https://play.google.com/store/apps/details?id=com.zencompass.liberate

Stop, Breathe and Think: Meditation and Mindfulness. *Stop, Breathe and Think* helps users become more aware of their moods and skills to manage emotional distress. It offers daily emotional check-ins and responds with daily meditation recommendations based on the user's mood and includes a daily mood-tracking feature that can be helpful for teens practicing self-monitoring and grounding. Practices are aimed at managing stress, anxiety, depression, and sleep problems. In addition, over 20 guided meditations are offered in Spanish. *Stop, Breathe and Think* offers foundational meditations for free and a premium subscription version that includes additional practices.

Website: https://www.stopbreathethink.com

Apple: https://apps.apple.com/US/app/id778848692?mt=8

Android: https://play.google.com/store/apps/details?id=org.stopbreathethink.app

Headspace: Meditation and Sleep. As one of the most popular apps, *Headspace* offers hundreds of sessions on physical health, personal growth, stress management, and anxiety relief. The app is organized by themed courses on a variety of topics, for example, managing anxiety, improving relationships, building self-esteem, transforming anger, dealing with sadness and grieving, mindful eating, and pain management. The *Sleep by Headspace* section includes sleep meditations and relaxing music. A number of the meditations are intended specifically for children and teens including "SOS exercises" in case of sudden meltdowns. The *Everybody Headspace* section provides opportunities to practice meditating in groups, which for teens, may add to its appeal. Although *Headspace* offers a free trial version, it is now mainly a premium subscription app.

Website: https://www.headspace.com

Apple: https://apps.apple.com/us/app/headspace-meditation-sleep/id493145008

Android: https://play.google.com/store/apps/details?id=com.getsomeheadspace.android

Sanvello: Stress and Anxiety Help. This app was developed by psychologists and integrates mindfulness with cognitive-behavior therapy skills using videos and audio exercises, mood and health habit tracking, and stress management tools. *Sanvello* also offers an interactive community forum that provides peer support. The basic version is available at no cost. The premium version includes additional features such as mood assessment tools. *Sanvello* also offers a HIPAA compliant version so that mental health clinicians can work with their clients, for example, by reviewing client assessment data and scheduling appointments.

Website: https://sanvello.com and https://www.sanvello.com/sanvello-for-clinicians

Apple: https://apps.apple.com/us/app/pacifica-for-stress-anxiety/id922968861

Android: https://play.google.com/store/apps/details?id=com.pacificalabs.pacifica&hl=en

Chapter 6. Mindfulness Exercises

Presented in this chapter are several meditative activities with instructions that the therapist might provide to support the client's meditation practice. However, the clinician may prefer a different meditational approach. If the current model is used, we recommend that the relevant instructions be copied and given to the youth for reference. The clinician should fill in the "___ *minutes*" parts with whatever number of minutes the client and therapist have agreed upon. For convenience, the following exercises are formatted for printing.

Although the adolescent is asked to practice these exercises at home on an ongoing basis, it is also helpful for him or her to meditate with the clinician in the first 5-10 minutes of each session, at least for the first few weeks, so that the therapist can monitor the client's progress and answer relevant questions. One proviso to any homework requirements is that the youth must feel safe at home. If this is not the case, for example when there is ongoing violence or threat of violence, or the client is homeless, we recommend that the youth practice meditation only within the treatment environment—for example in the first 10 minutes of each session. This likely slows down the client's acquisition of meditation skills, but it reflects the underlying imperative that meditation only occur in safe environments, where hypervigilance is unnecessary. In our experience, session-only meditation practice can still be an effective way for the client to gain mindfulness skills.

Facilitating Basic Mindfulness Exercises

When stressed, many individuals breathe more shallowly, hyperventilate, or in some cases, temporarily stop breathing altogether. Teaching the adolescent "how to breath" during stress can help restore more normal respiration, and thus adequate oxygenation of the brain. Equally important, as the client learns to breathe in ways that are more efficient and more aligned with normal, non-stressed inhalation and exhalation, there is usually a calming effect on the body and the autonomic nervous system.

Breath training generally involves guided exercises that teach the client to be more aware of his or her breathing—especially the ways in which breathing is inadvertently constrained by tension and adaptation to trauma—and to adjust his or her musculature, posture, and thinking so that more effective and calming respiration can occur. The mindful breathing exercises shown below offer one approach to breath training.

Offer the client some basic background information about meditation.

1. Before beginning, explain to the client that learning to pay attention to breathing, and learning to breathe deeply, can both help with relaxation and be useful for managing fear or anxiety. You may note that when we get anxious or have a panic attack, one thing that happens is that our breathing becomes shallow and rapid. When we slow down fearful breathing, the fear itself may slowly decrease.
2. Explain that, initially, some people might become dizzy when they start to breathe more slowly and deeply—this is a normal reaction. For this reason, they should not try breathing exercises standing up until they have become more experienced and comfortable with them.
3. You might want to note that the exercises could feel a little strange at first because the client will be asked to breathe into his or her belly (i.e., abdominal breathing).

Go through a five-step sequence with the client. After each step, "check in" as appropriate to see how the client is feeling, and ascertain if there are any problems or questions.

1. Invite your client to sit in a comfortable position. If the adolescent is comfortable with closing his or her eyes, ask him or her to do so. Some trauma survivors will feel more anxious with their eyes closed, and will want to keep them open. This is entirely acceptable. If they prefer to keep their eyes open, the client can be invited to take a "soft gaze" (un-focusing the eyes) while looking slightly downward at the floor about three feet ahead.
2. Ask the client to begin breathing through the nose, paying attention to the breath coming in and going out. Do this for 5 or 6 breaths. It is usually helpful for the clinician to breathe along with the adolescent, at least at the beginning of the exercise. You can guide him or her for each inhalation and exhalation, saying "in" and "out" to help him or her along.
3. Ask the adolescent to imagine that each time he or she breathes in, air is flowing in to fill up the abdomen and lungs. It goes into the belly first, and then rises up to fill in the top of the chest cavity. In the same way, when breathing out, the breath first leaves the abdomen, and then the chest. Some people find it helpful to imagine the breath coming in and out like a wave. Do this for another 5 or 6 breaths.
4. Explain that once the client is breathing more deeply and fully into the belly and

chest, the next step is to slow the breath down. Ask the client to slowly count to three with each inhalation and exhalation—in for three counts, out for three counts. With practice, the client may begin to slow his or her breath even further. Tell him or her that there is no specific amount of time necessary for each inhalation and exhalation, only that he or she try to slow his or her breathing. Do this for 5 or 6 breaths.

5. Invite the client as best they can, to stay "in the moment" while doing breathing exercises. When his or her mind wanders (e.g., thinking about school, dinner, or an argument with someone), instruct him or her to just gently note the wandering, and then choose to bring the mind back to the immediate experience of breathing.

Invite the client to practice this sequence at home for 5 to 10 minutes a day. It can be helpful if he or she chooses a specific time of day (e.g., in the morning, before work or school, or just before sleep), and make this exercise a regular part of his or her daily routine. The adolescent should sit or lie down at home in a comfortable position, with as few distractions as possible (e.g., no smartphone, television, or internet) for this practice.

Eventually, the youth can extend these exercises to other times during the day as well, especially when relaxation would be a good idea (e.g., in stressful social situations or whenever he or she feels especially anxious). Remind the client to internally count to three during each inhalation and exhalation, since the counting often serves to trigger the relaxation response.

Basic Meditation Instructions

Find a quiet place where you can be alone without interruption for ___ to ___ minutes (whatever amount of time has been agreed upon). It can be helpful to use this same place every time you meditate. If you can, do this exercise at the same time every day.

1. Sit in a chair, or on the floor, with your back straight and your hands in your lap. You can lie down, if you wish, but this may make you sleepy and make it harder to concentrate.
2. If you feel comfortable, close your eyes, or at least lower your eyelids. If this makes you nervous, it is fine to leave them open. If you want to keep your eyes open, lower your eyelids and take a soft focus on the floor about three feet in front of you.
3. Begin by bringing attention to your breath: feel the air going into your lungs, notice the pause between breaths, and then feel the air going back out. Just watch the breath go in, and then go out. You don't have to slow it down or speed it up.
4. When you notice that your mind has started thinking about other things, just remind yourself to go back to paying attention to your breathing—watching and feeling the breath go in and out. Most people sometimes have a hard time just paying attention to their breath. The mind wanders. That's okay—it's just what minds do. There is no need to criticize yourself when this happens, just notice that you were thinking, and then go back to watching yourself breathe in and out. Let your thoughts and feelings come and go. Thoughts and feelings are neither good nor bad, right nor wrong—they are just thoughts and feelings that come and go. Notice them, but then return to watching your breath.
5. Try to do this for 5 to 10 minutes a day, for at least four days a week. You can set a timer on your phone or an alarm clock to keep track of the time, so you don't need to watch the time. If it has been less than 10 minutes, and you can go a little longer, just go back to paying attention to your breath. Eventually, you may want to spend more than 10 minutes mediating, or you may want to meditate more often. It is up to you.
6. When you have finished your meditation practice, remember to fill in your *Daily Meditation Record*, so you can share it with your therapist the next time you meet.

Mindfulness-Based Breath Training (MBBT; Briere & Semple, 2013)

MBBT can be useful for grounding and calming turbulent emotions, and offers support for managing physical pain. However, MBBT should not be used as an exercise to increase tolerate to pain associated with self-injurious behaviors.

1. Start by sitting or lying in a comfortable position. Plan to spend the next 5 to 10 minutes paying attention only to your breathing. If you are comfortable doing so, close your eyes.
2. Begin breathing through the nose, if you can, paying attention to the breath coming in and going out. **Notice** how long each in-breath and out-breath lasts. Do this for three breath cycles (sets of breathing in and breathing out).
3. Shift your attention to breathing into and out of your **abdomen**. Note that the belly rises with each in-breath and falls with each out-breath. Air should flow in to fill up the abdomen and then lungs. When breathing out, the breath first leaves the abdomen, and then the chest. Do this for three breath cycles.
4. The next step is to **slow** the breath down. Count slowly to **three** with each in-breath, pause, and then count to **four** with each out-breath. The out-breath should take a little longer than the in-breath. At the end of the out-breath, pause until you feel the need to inhale again. The actual speed of the counting is up you, although it should be slower than usual.
5. **Focus** your mind on counting during breathing. Bring your attention back to counting whenever you notice that you have been distracted by pain or by a thought, feeling, or memory. It is normal to lose track of counting, and doing so is not "wrong" or "bad." You are learning to let go of distractions and stay in the present moment, while relaxing and breathing. The aim is simply to notice when your attention has wandered. Then just return your attention to counting within each breath.
6. It may help to **imagine** breathing in peace and strength, and breathing out tension.
7. Then return attention to counting within each breath.
8. When you have finished your meditation practice, remember to fill in your *Daily Meditation Record*, so you can share it with your therapist the next time you meet.

The Mindful HALT (Semple & Willard, 2019)

Bringing awareness to the basic needs of your mind and body can help you think and see more clearly, make better decisions, and manage your impulses. When you are aware of internal experiences, you can give our body and brain what they need to perform their best. In this exercise, you will ask yourself a series of questions that bring attention to your needs in this moment. You can practice the Mindful HALT every day just to get to know your mind and body's needs. It can be especially useful to do if you feel yourself starting to get upset or distressed. You can HALT any time but the more you practice bringing awareness to your basic needs, the more you can skillfully manage your thoughts, emotions, and behaviors.

1. You may stand, sit in a chair or on the floor, or lay down. If you are comfortable, you may close your eyes or just let your eyes take a soft gaze.
2. Begin by taking five long, deep breaths in and five long deep breaths out. With each breath, let your body relax more and more. Then, start to check in with yourself using the acronym **HALT**.

H Are you feeling **HUNGRY**? Check in with your stomach. How is your overall energy? If you are hungry, your body and brain don't have the fuel they need to think and see clearly or manage your emotions and impulses. If you're hungry, plan a meal or a snack.

A Are you feeling **ANGRY** or **ANXIOUS**? These two emotions can really affect your perception of danger and safety, and ability to think things through clearly. If your body or brain are experiencing these emotions, a few mindful breaths can help them settle.

L Are you **LONELY** right now, feeling isolated or disconnected? Loneliness is different than being alone. Sometimes, you can be surrounded by people but still feel alone. Reaching out to others can help you gain perspective and feel better really quickly. There's an old saying that says if your mind is a dangerous neighborhood, don't go there alone. Who could you reach out to in this moment?

T Are you **TIRED** right now? Maybe you're not getting enough sleep, or maybe you are just worn out from school, work, or relationship drama. When you're tired, it's almost like you aren't as smart as when you are well rested, and it's much harder to regulate your emotions and impulses. What can you do to rest or relax, if not now, then soon?

3. When you have completed the HALT exercise, add it to your *Daily Meditation Record.*

Mountain Meditation[4]

Life is full of unexpected challenges. People around us may be kind one day and mean the next, schools change, friendships change. Change can sometimes be difficult. But even with all the changes going on around us, we can remain calm and stable. Think about a mountain—it's always calm and still, despite the rain or shine, sunshine or fog, regardless of the seasons, it just sits—calm and still, while the weather and the world swirl around it.

1. Sit or stand up straight and tall like a mountain. With each breath, you might say to yourself, "*Breathing in, I see myself as a mountain, breathing out, I feel calm, stable, and still.*" Take three or four deep breaths until you feel like a mountain—calm, stable and still.
2. Then, imagine being a mountain in the summertime. You might have snow at your peak and meadows with green trees on your sides. Day after day goes by. The wind and weather, the grass and trees, the light and darkness constantly change. But through it all, the mountain remains calm, stable, and still.
3. Then autumn comes—the trees start to change colors, leaves fall away, and the grass turns brown. Birds fly south and animals may hibernate. The days grow shorter and colder, the nights longer. And through it all, the mountain remains calm, stable, and still.
4. Winter gradually arrives. Snowstorms blanket the mountain in deep snow, covering its rocky sides and meadows in white, every tree sparkling with ice crystals. The nighttime stars appear cold and bright. And yet the mountain remains calm, stable, and still.
5. Eventually winter fades into spring. The snow melts into waterfalls that cascade down the sides of the mountain. Flowers bloom, and buds sprout on trees and begin to turn green. The days grow longer and warmer. Spring fog may arrive some days, sunshine or rain on others, but through all of these changes, the mountain is calm, stable, and still.
6. While the world is always changing, you always carry this stillness deep inside yourself. You can allow your mind and body to rest when needed by repeating to yourself "*Breathing in, I see myself as a mountain, breathing out, I feel calm, stable, and still.*"
7. When you have finished this exercise, remember to fill in your *Daily Meditation Record*.

[4] This activity was adapted from the *Mountain Meditation* for adults developed by Jon Kabat-Zinn (2014) with imagery from Thich Nhat Hanh (1991).

Mindfulness of Sounds[5]

Many adolescents spend lots of time every day with their earbuds in listening to music. Have you ever tried to practice mindfulness in everyday life by discovering music in ordinary sounds? We can learn to hear music in all the sounds around us simply by letting go of our expectations of what music is. How might doing that affect how you feel?

1. Sit in one spot and start by settling yourself by taking a few deep in-breaths and out-breaths. Close your eyes only if you feel comfortable doing so, or just take a soft gaze on the ground in front of you.
2. Then spend ___ to ___ minutes really listening to the sounds around you. When other thoughts or sensations distract you from the sounds, simple note the distraction, and then return your attention to mindful listening.
3. You might try finding the music in loud or harsh sounds—like the sharp notes of a dog barking or the rhythmic crunching of a garbage truck doing its job.
4. With mindful awareness, you can listen to a rich symphony of sounds heard on a busy city street. Can you hear the chorus in many voices talking at the same time on a subway platform or in a crowded street fair? Do you hear the music in the honking of cars at an intersection?
5. When was the last time you stopped to listen to the sounds of the wind, the birds in the trees, or other sounds of nature? If there is an ocean or a stream near you, listen carefully to hear its song.
6. When you have finished practicing mindfulness of sounds, remember to fill in your *Daily Meditation Record*.

[5] This activity was adapted from *The Mindfulness Matters Program* (Semple & Willard, 2019).

Chapter 7. Metacognitive Awareness of Posttraumatic Triggers and Intrusions

As noted earlier, a primary benefit of mindfulness is the development of metacognitive awareness—the realization that thoughts and emotions are products of the mind and not necessarily true representations of reality. In this regard, mindfulness not only involves the sustained capacity to focus awareness, but also the ability to "watch" thoughts and feelings go by, noticing them as they arise in the mind, but then letting them go as the meditator returns their attention to the breath. As the youth becomes increasingly aware that the mind almost constantly generates internal chatter (referred to by many meditators as "monkey mind"), they may begin to realize that not everything they feel needs to be taken as seriously as previously thought. The clinician may reinforce this important insight during treatment, for example by noting:

> *Thoughts are just what the mind does. It thinks, all the time. Sometimes the thoughts make sense, sometimes they don't, but that's all they are, just thoughts... stuff that happens inside our head. Sometimes we feel bad because we believe our thoughts, but many times, our thoughts are actually wrong. For example, you might say something mean to yourself that really isn't true. Maybe you think something that you learned a long time ago, from someone who hurt you or shouldn't be believed. When thoughts like that show up, it helps to remind yourself that they are just thoughts, not facts. Just let them be thoughts, always coming and going, not real, and not necessarily true.*

This reduced identification with internal processes can help the youth manage the intensity of strong emotions. By practicing looking at thoughts as "just" thoughts—ever changing and often unrelated to what is true in the present—the adolescent may learn that they don't need to believe (or react to) everything they think. Thoughts are not facts. Thoughts are just thoughts. When offering meditation instructions, this might be highlighted by saying something like:

> *When you meditate, you practice letting your thoughts and feelings come and go, while remembering that they are just your mind talking, just thoughts, memories, things you say to yourself that, lots of times, don't have much to do with your life right now. Just notice the thoughts, and then go back to paying attention to your breath.*

Trigger Management

Although often taking advantage of previously established mindfulness skills—ideally

developed through meditation—this chapter is also concerned with other ways to increase metacognitive awareness. Especially through an exercise called the *Trigger Grid* (Briere & Lanktree, 2013), the youth can learn how to deal with times when reminiscent stimuli in the environment trigger painful negative states and cognitions associated with early abuse, neglect, or attachment insecurity. Although not meditational, this is an explicitly metacognitive task. It involves learning how to discriminate trauma- or attachment-related thoughts and feelings from here-and-now events happening in the "real" world.

The process of identifying triggered thoughts, emotions, or body sensations, correctly attributing them to the past rather than the present, and then intervening before they can create extreme distress or motivate DRBs, is referred to as *trigger identification and intervention* in the ITCT-A Treatment Guide, or, in this chapter, as *trigger management*. It is facilitated in ITCT-A through use of the *Trigger Grid* found in Appendix B and is also available as a downloadable PDF at no cost on the internet at *attc.usc.edu*). This tool is specific to ITCT-A, so clinicians using other treatment approaches may not choose to employ it—although they are welcome to do so if they wish.

Although the *Trigger Grid* can be used by adolescents who have not meditated, the meditation and mindfulness exercises presented in this guide can significantly advance cognitive and emotional trauma processing. By responding to the items of the *Trigger Grid*, the client is prompted to develop greater mindfulness and metacognitive awareness of triggering events and triggered thoughts, sensations, and feelings, which, in turn tends to decrease their emotional impact, and creates opportunities for the teen to make more skillful response choices. Trigger management via the *Trigger Grid* helps the youth to:

- learn about triggers, including their historic nature;
- identify specific instances during which he or she has been triggered;
- determine, based on these times, what seem to be major triggers in his or her life;
- learn to identify when he or she is being triggered;
- detect the "unreal" (not-here, not-now) nature of triggered thoughts and feelings; and
- develop strategies that might be effective in managing emotional and behavioral responses once the triggering has occurred.

Importantly, work with the *Trigger Grid* is most effective when it occurs *before* the client

is triggered in his or her environment. The goal is for the youth to explore and problem-solve future triggers before they happen, since the best time to figure out what to do when triggered is rarely after one has been triggered and has lost perspective. In this regard, learning to identify triggers (or infer their likelihood), and then work out ways to either keep from being triggered, or to mitigate triggered states, can be an ongoing part of treatment for maltreated youth. The following are the primary items of the *Trigger Grid* (see Appendix B for the entire form). The clinician may also wish to consult the ITCT-A Treatment Guide for additional information.

What is a trigger? This first question introduces the metacognitive notion that there are things in the current environment that, by virtue of their similarity to aspects of prior traumas or attachment problems, can activate early memories in the form of intrusive emotions, thoughts, and sensations. It is best if the youth can attempt to answer this question without excessive therapist's guidance. If the adolescent is unfamiliar with the term, however, the clinician may say something like:

> *Sometimes people are reminded of something in the past, and it makes them feel or think the way they felt way back then. For example, someone might say or do something that reminds you of how you were treated badly when you were young. Or, something might happen that suddenly makes you feel like you are a child again, being hurt or rejected like you were back then. When those kinds of things happen, we call the thing that reminded you of the past a "trigger." So, for example, if someone yelled at you, and it made you feel like you were back in the past when you used to get yelled at a lot, we would say that being yelled at is a trigger.*

In some cases, triggers and triggering will be harder for the youth to understand, and the therapist may have to devote some time to explaining the concepts involved. In other cases, this step will be relatively straightforward.

Times I have been triggered. This question also increases metacognitive awareness of triggering, since it focuses the client on times when triggering occurred in his or her life. If the youth can actually name some specific occasions when he or she was triggered, the process of doing so reinforces the reality of triggering, increasing the client's acceptance that triggering is a real thing that has actual relevance to them. Although it is important for the client to be able to identify their own triggers, if they have difficulty naming any triggering event, you might help out by offering just one example from the client's own experience with which you are familiar,

and then probe with follow-up questions to elicit additional triggers.

What happened when I got triggered? Answers to this question are broken down based on a series of sub-items, answered for a number of triggers. For each trigger, these are:

- What I thought after this trigger.
- What I felt after this trigger.
- What I did after this trigger.

Answers to these questions delineate the triggering process, by having the youth describe in detail (a) the trigger and (b) their cognitive, emotional, and behavioral responses. This further emphasizes the reality of triggering and responses to triggering, which reinforces the fact that the client can be triggered, and then have a host of reactions that seem like they are related to the present but are actually based in the past. Once the unreality of the triggered state is established, the youth might discover that, in a sense, there is little to be upset about in the here-and-now.

Of course, some triggers are reminiscent of the past because they are, in fact, currently abusive or traumatic. For example, a step-father's raised voice may be triggering not only because it reminds the client of previous maltreatment by an abusive caretaker, but also because the step-father is, in fact, being verbally and/or emotionally abusive. This should always be pointed out to the youth. Just because something is triggering doesn't mean that it does not signal some level of current danger. Even when this is true, however, the activation of memory-related distress may interfere with the client's ability to avoid or address currently dangerous situations. In this sense, the mindful examination of triggers inevitably includes the question "how much of my response is due to the past, and how much is based on the present?"

What kinds of things have triggered me? (What are my triggers?). Answers to this question allow the client to identify as many triggers as possible, which serves a major function in trigger management. In this regard, the client's recognition that there is a trigger in the environment can be a cue to them that a triggered state is potentially upcoming. This can also help the youth understand that multiple triggers may derive from a single incident. The metacognitive realization, in turn, undercuts the likelihood that they will believe that an intrusive feeling, thought, or sensation exists due to events in the "real" world. In other words, if the youth can infer that they are being triggered by virtue of the presence of a known trigger, they will be less likely to believe that they are "really" mad or "really" frightened about something happening in the present.

The appreciation that "this isn't real" can reduce the power of the memory activation, and thus its degree of aversiveness. It also may reduce the likelihood of behaviors that only make sense were the event actually occurring in the present. For example, a youth who is triggered into feeling that they are being disrespected or devalued by another youth will be less likely to assault that youth if they know that "this is just the past talking" rather than reflecting an actual, current instance of maltreatment.

Although the adolescent client may become relatively adept at identifying triggers, some may be overlooked. In such cases, the clinician may prompt additional responses to this *Trigger Grid* item by asking the youth about common triggers, to see if any of them relate to the client's own experience. These include:

- interpersonal conflict,
- sexual situations or stimuli,
- angry people,
- intoxicated people,
- a specific smell,
- a perceived physical similarity to a previously abusive person or dangerous situation,
- seemingly arbitrary criticism or accusations,
- perceived rejection or abandonment,
- feeling ignored or dismissed,
- interactions with authority figures,
- unwanted physical touch,
- hearing gunshots, or
- the sound of crying.

The locations where past traumatic events happened are also common triggers. These can include, for example, walking by the storefront where a shooting had been observed or returning to the room in which a sexual assault occurred.

How do I know I've been triggered? As noted in the ITCT-A Treatment Guide, it is not uncommon for someone to be triggered, but attribute their reactions to the immediate environment rather than to a past maltreatment. For example, an adolescent who is triggered into painful childhood memories during an argument with a friend might easily attribute their anger and distress to the friend's behavior, rather than to the parental maltreatment that created

the triggered memory in the first place. Such "source attribution errors" (Briere, 2002) can be problematic because they confuse triggers with etiologies. The youth thinks the friend's behavior is the primary source of their anger, when the present conflict is, in fact, the trigger of emotional pain, not its direct cause.

Beyond increasing the client's mindful awareness of triggers and triggering, the most important function of this *Trigger Grid* item is to increase the youth's understanding of the immediate effects of triggers, so that this information can be applied in future situations where triggering has occurred but, for whatever reason, the client is unaware of it. By listing as many responses that followed known instances of triggering, the client creates an "early warning system" that can alert them to the possibility that triggering has taken place, using their own reactions as a kind of barometer. Client responses to this *Trigger Grid* item thereby decrease source attribution errors about triggered states, and help the client to infer the presence of triggering based on reactions that commonly followed previous instances of triggering in the past. In some cases, this is not difficult. For example, it may not be hard to recognize an intrusive sensory flashback of a gunshot as posttraumatic, given that one has been shot in the past. In others, however, triggered re-experiencing may be more subtle, such as feelings of anger or fear, or intrusive feelings of helplessness or paranoia that emerge "out of nowhere" during an interpersonal interaction. In the latter cases, the client's only information that they may be triggered is the extent to which their current reactions are similar to other times when they responded to a known trigger. Answers to the *How do I know I've been triggered* item often include at least some of the following:

- a thought, feeling, or sensation that doesn't fully "make sense" in terms of what is happening around the survivor;
- thoughts or feelings that are too intense, based on the current context;
- thoughts or feelings that carry with them memories of a past trauma;
- sudden somatic responses, such as a tightening of the scalp, an increased heartrate, or shortness of breath; or
- an unexpected alteration in awareness (e.g., depersonalization or derealization) as these thoughts, feelings, or sensations occur.

What could I do or say to myself so that I wouldn't get triggered? In some cases, the youth may be able to identify or infer a trigger in time to avoid its most serious effects. For example, if

a youth notices that a known trigger is present (e.g., watching a movie that suddenly becomes violent or sexual), or suspects it (e.g., because they suddenly feel dizzy or nauseous), they may be able to avoid a full triggered response simply by leaving the theatre. Similarly, an adolescent with a history of sexual abuse who suddenly feels upset during a consensual sexual interaction, or notices that a triggering sexual act is impending, can terminate the sexual contact or perhaps avoid the specifically triggering act.

The youth may also be able to verbally warn themself that triggering is likely. Although this might seem redundant, since the survivor would have to know about the possibility of a trigger in order to identify it as such, it is sometimes the case that articulated warnings (whether verbalized or just noted in the mind) have more metacognitive impact than thoughts alone. This is sometimes called the "think-aloud" technique (Ward & Traweek, 1993). For example, the client might say to themself:

- "This is a situation where I get triggered."
- "This guy's flirting is starting to remind me of my father."
- "I better leave this party before I get triggered and act out."
- "This argument is getting out of control, and I'm starting to feel triggered."

What could I do after I get triggered that would make it better? This question is especially important because it prompts discussion and problem-solving about future triggering. Because this is discussed in sessions before the triggering actually takes place, it proactively prepares the client to deal with triggered states. There are many possible strategies the client can use to mitigate triggered responses, some of which may be specific to a single trigger or event, while others may be generally helpful for many events. For example, a client might develop one set of strategies for dealing with sexual triggers, another set for triggers involving interpersonal rejection or conflict, and another for instances when he or she is triggered by gunshots or sirens.

Strategies for Managing Triggers

Self-calming behaviors. One option for dealing with triggered states is to practice self-calming behaviors. One of the most obvious first things a triggered person can do is use the settling skills described earlier, especially *grounding* and *mindful breathing*.

- *Grounding* is often taught as a specific skill in trigger management. Typically, grounding involves the client directing their attention away from distressing, often escalating internal states onto the therapist, the therapy, and/or the external

environment. For example, the youth might be asked to describe the room around them, the feeling of the chair or couch beneath them, or the soles of their feet on the ground. In more extreme cases, the clinician may ask the client about the current date, location, or time. Often the therapist will accompany this exercise with statements about current safety (e.g., "You are okay." "You're here in the room with me." "You are safe."). The clinician is referred to the highly useful text, *Seeking Safety* (Najavits, 2002) for more grounding techniques.

- *Mindful breathing* involves breathing in a specific way that leads to reduced anxiety and autonomic arousal, and greater mindfulness. Like the meditation procedures discussed in Chapter 6, we recommend that the client practice this method within sessions, and then at home for 5 to 10 minutes, multiple times a week, preferably in the same place and at the same time. You may wish to review the instructions for facilitating mindfulness practices and the mindful breathing exercise, both of which are described in Chapter 6.

Eventually, the youth can apply these settling exercises outside of the session, during times when they are experiencing a triggered state.

Strategic distraction. Somewhat similar to grounding, strategic distraction involves shifting the client's attention away from a triggered state until it fades (habituates) from lack of attention or reinforcement. Instead of orientation to the external environment, however, distraction focuses the client's attention on activities that preclude internal preoccupation. In some cases, this is done immediately upon recognition that one has been triggered. In other cases, it may be invoked minutes or hours later, as a way to maintain internal stability in the face of what would otherwise be sustained distress. Examples of strategic distraction that can be used immediately after a trigger include:

- Going for a walk,
- Calling/texting a safe and supportive friend, or
- Engaging in physical exercise.

More time-extended distraction activities include:

- Reading, watching TV;
- Taking a bath;
- Listening to music; or

- Interacting with, or cuddling, a pet.

Notably, like grounding, distraction exercises rarely "fix" the underlying problem of easily triggered distress. Instead, they are temporary measures that reduce distress to a tolerable level following a triggering event. They do not help the client process the trauma memories as much as help them briefly to avoid them. Yet, these activities can be useful ways to take control over triggering environments and thus reduce the immediate likelihood of destabilizing distress and problematic behavior.

Self-talk can be another useful strategy. Self-talk occurs when the client, in a sense, "talks-back" to triggered intrusive cognitions that may involve, for example, themes of low self-esteem, self-blame, perceived abandonment, helplessness, hopelessness, or unworthiness. There are two forms of self-talk that the youth can employ when triggered. The first involves formulating positive rebuttals to negative self-statements. The other involves metacognitive statements that remind the youth that they are experiencing triggered memories, not receiving information from the here-and-now. Examples of positive self-talk, which may be verbalized at the time of a trigger or just internally sub-vocalized include:

- "I am a good person."
- "I can handle this."
- "I don't have to do anything I don't want to do."
- "I've done nothing to be ashamed of."
- "I am worthy of respect/love/happiness."

Metacognitive self-statements, which remind the youth that they are, in a sense, remembering, not perceiving immediate reality, include:

- "This is just a flashback; it's not real."
- "This is the past, not the present."
- "These are just thoughts, they aren't necessarily true."
- "I'm being triggered. These are just memories from the past."

Urge surfing or emotion surfing is used primarily to (a) reduce the frequency and intensity of problematic substance use or DRBs, and (b) increase distress tolerance. Many triggered emotional states have a relatively short half-life—if the individual can sit through the triggered emotion in a mindful manner, without excessive avoidance, the urges will decrease or change, usually within a few minutes, which reduces the need for DRBs or substance use. With

continued practice, the period between the initial triggered experience and the actual DRB may be lengthened. As distress tolerance increases, the DRB itself may decrease in frequency or severity, or may cease to occur at all.

Based upon the notion that, "you can't stop the waves, but you can learn to surf" (Kabat-Zinn, 1994, p. 32), the authors of Mindfulness-Based Relapse Prevention (MBRP; Bowen et al., 2010; Marlatt & Donovan, 2005) suggest that mindfully observing triggered distress or the urges to engage in a DRB or substance use is similar to riding a wave—the urge or emotion slowly builds, peaks relatively quickly, and then slowly falls away. MBRP encourages the client to pay mindful attention to the transient aspects of triggered states, and simply to allow the experience of distress to come and go, without engaging in the avoidance reflected by DRBs and substance use.

Urge surfing can be taught to traumatized youth as a series of behaviors that call upon meditation and mindfulness practice. These include aspects of trigger management described above, as well as an "emotion surfing" component. The following steps are an adaptation of the MBRP *Surfing the Urge* exercise for youth struggling with overwhelming emotions and urges to use substances or engage in DRBs. The exercise that follows is an abbreviated version that can be used as a client handout. The clinician is referred to Bowen and her colleagues (2010) for a more extended discussion of MBRP and urge surfing.

A Brief Urge Surfing (Emotion Surfing) Exercise

When you have been triggered and find yourself suddenly feeling the urge to drink, use drugs, or engage in behaviors that are not helpful for you, find a safe, quiet place where you can sit and go through the following steps.

1. *Recognize, without judgment, that you have been triggered*, based on what you are feeling or thinking, or because you are aware of one or more triggers in the environment.
2. *Notice how these triggered feelings, thoughts, or urges are experienced in your body*, both in terms of location (e.g., the stomach or chest) and the types of sensation (e.g., pain, pressure, turmoil).
3. Now *focus your attention on your breathing* for several minutes, feeling the air going through your nose and into your lungs, pausing your breath, and then letting it go, feeling the air leave your lungs and out through your nose.
4. Now *return your focus to the distressing emotions or urges* as they appear in your body. Sit with these feelings for several minutes, or as long as you can without being overwhelmed.
5. Now *return your attention to your breath* for several minutes. Do your best to allow yourself to have the triggered feelings or urges, without acting on them—if you try to block them, they will likely become stronger.
6. Imagine *surfing on these waves of feeling*, neither blocking them nor acting upon them, just letting them happen... surfing over the feelings as they arise and then slowly fade.
7. *Repeat these steps* as many times as necessary, watching the feelings repeatedly arise and fall away. Imagining that you are *surfing these waves of feeling*, neither blocking them nor acting upon them, just letting them happen.
8. When the feeling or urge has passed, you can stop the exercise.
9. After you have finished your urge surfing practice, add it to your *Daily Meditation Record*, so you can share it with your therapist the next time you meet.

Chapter 8. In Closing

We'd like to close this guide by sharing a few thoughts about becoming a mindful therapist. Many aspects of mindfulness are taught through the embodiment of mindfulness (Shapiro & Carlson, 2009). Along with others, we believe that the best way to embody mindfulness is by practicing mindfulness ourselves. To become a mindful therapist, your guidance must be grounded in your own experiences and your own mindfulness practice. From this foundation, you teach mindfulness by practicing with your clients and speaking from your own experiences. As mindful therapists, we teach by modeling mindful attitudes, actions, behaviors, language, and attentiveness to our client's experiences. If you adopt a "do as you're told, not as I do" attitude, you will almost certainly face some resistance (Semple & Willard, 2019). Cultivating mindfulness, however, takes work. It takes time, and discipline, and consistent practice. And so you might be asking yourself, "Why should I do all this work to become a mindful clinician?"

As we mentioned earlier, being a calm, grounded clinician who is attuned to your client's needs supports his or her healing. Mindful clinicians refrain from criticism, judgments, or judgmental language. Adopting an attitude of curiosity and openness to your client's experiences invites the adolescent to become curious about his or her own experiences. Arising from your own practice, you will find your own voice and discover your own creative ways to teach mindful awareness to others. As therapists, we are trained to have certain expectations. One that is central to therapy is that we expect our clients to change. The unconditional acceptance that is cultivated from mindfulness practice means that we are accepting of *whatever* is in this moment. Even if what is happening may not be to our liking. It can be both challenging and immensely rewarding to simply stay present, let go of your expectations, and trust the therapeutic process.

There are also myriad direct benefits to you in becoming a mindful clinician—even if you never teach mindfulness to any of your clients. Burnout and compassion fatigue is a significant risk among mental health providers (Ray et al., 2013), particularly those who work in the field of trauma (Waelde et al., 2016). There is now substantial research that shows mindfulness can decrease stress, anxiety, and burnout in healthcare providers (e.g., Escuriex & Labbé, 2011; Goyal et al., 2014; Ruths et al., 2013; Scarlet et al., 2017). Mindfulness can help focus your attention (Semple, 2010) and tune in with great precision to your own thoughts and feelings,

which can help you make more skillful decisions both in the therapy room and elsewhere in your life. Mindfulness, like laughter, can be contagious. Cultivating presence and compassion in your own life spreads to your family and friends around you. We encourage you to explore the personal benefits that can be gained by practicing mindfulness in your own life.

Appendix A. Daily Meditation Record

Daily Meditation Record Name____

Date	How long did you meditate today? (check one)	How did it go? It was easy	It was okay	It was hard	Notes
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	
	☐ I didn't ☐ 1-5 minutes ☐ 6-10 minutes ☐ 11-15 minutes ☐ more than 15 minutes	☐	☐	☐	

Appendix B. The Trigger Grid for Adolescents

The Trigger Grid for Adolescents, 2nd edition (TG-A-II)

1. **What is a trigger?**

_____

_____

_____

_____

_____

2. **Times you have been triggered (pick up to 7 of the most upsetting times)**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

3. **For each of these times, what happened when you got triggered?**

Trigger #	What I thought	What I felt	What I did
1.			
2.			
3.			
4.			
5.			
6.			
7.			

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The Trigger Grid for Adolescents, 2nd edition (TG-A-II)

4. Looking back, what kinds of things have triggered you (What are your triggers?)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

5. Looking back, what happened after you were triggered that might tell you that you are being triggered in the future?

☐ You had a flashback	☐ You spaced out or went away in your mind	☐ It was hard to breath
☐ Your heart started going fast	☐ You suddenly got a headache	☐ You felt dizzy
☐ You felt like things weren't real	☐ You had thoughts that didn't make sense	☐ You felt sick
☐ Your body felt strange or weird	☐ You suddenly felt like you were in the past	☐ Your face got hot

☐ You were way more upset or angry or scared than made sense

Anything else?_____

_____

_____

The Trigger Grid for Adolescents, 2nd edition (TG-A-II)

6. Looking back, was there anything you could have done so that you wouldn't have gotten triggered?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

7. What do you think you could do after you get triggered that would make it better and you wouldn't get so upset, scared, or mad:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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